Filing at a Glance

Company:	American Heritage Life Insurance Company
Product Name:	Medical Examination
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	09/13/2012
SERFF Tr Num:	ALST-128683900
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	ABJ745AR
Implementation Date Requested:	On Approval
Author(s):	Patti Hicks, Sara Welch, Josefin Sison
Reviewer(s):	Linda Bird (primary)
Disposition Date:	09/18/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *American Heritage Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Medical Examination*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Patti Hicks

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 09/18/2012
State Status Changed: 09/18/2012
Created By: Patti Hicks
Corresponding Filing Tracking Number:

Filing Description:

Re: Filing for American Heritage Life Insurance Company
NAIC No. 60534
Medical Examination Form ABJ745AR

To Whom It May Concern:

Form ABJ745AR is being submitted for your approval. This form will replace AWD745AR-1 which was approved by your Department on 07-18-2005. This form will be used to obtain medical information required for the underwriting of life insurance.

Please note that this filing is replacing a previously approved filing ALST-128664351 approved on 09-11-12. Please apply the filing fee from that filing to this one.

We have bracketed certain portions of the form to allow for flexibility as follows:

• The address on the form will be the current address of American Heritage Life Insurance Company.
• We may delete use of prescription medication history in accordance with our current underwriting standards.

If you have any questions regarding this filing, please contact me at patti.hicks@allstate.com, or (904) 992-3424.

Company and Contact

Filing Contact Information

Patti Hicks, Senior Filing Analyst
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

patti.hicks@allstate.com
904-992-3424 [Phone]
904-992-2975 [FAX]

Filing Company Information

American Heritage Life Insurance Company
ATTN: Legal/Compliance
1776 American Heritage Life Drive
Jacksonville, FL 32224-9983
(904) 992-1776 ext. [Phone]

CoCode: 60534
Group Code: 8
Group Name: Allstate
FEIN Number: 59-0781901

State of Domicile: Florida
Company Type: Life and Health
State ID Number:

State: *Arkansas* ***Filing Company:*** *American Heritage Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Medical Examination*
Project Name/Number: */*

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation: $50.00 x 1 form = $50.00 - We respectfully request that the filing fee from withdrawn filing ALST-128664351 be applied to this filing. Thank you very much.
Per Company: No

Company	Amount	Date Processed	Transaction #
American Heritage Life Insurance Company	$50.00	09/13/2012	62644345

SERFF Tracking #:	*ALST-128683900*	***State Tracking #:***		***Company Tracking #:***	*ABJ745AR*

State:	*Arkansas*	***Filing Company:***	*American Heritage Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Medical Examination*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/18/2012	09/18/2012

SERFF Tracking #:	*ALST-128683900*	***State Tracking #:***		***Company Tracking #:***	*ABJ745AR*

State:	*Arkansas*	***Filing Company:***	*American Heritage Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Medical Examination*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/18/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Medical Examination Form		Yes

SERFF Tracking #:	*ALST-128683900*	***State Tracking #:***		***Company Tracking #:***	*ABJ745AR*

State:	*Arkansas*	***Filing Company:***	*American Heritage Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Medical Examination*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: ABJ745AR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		ABJ745AR	AEF	Medical Examination Form	Revised: Replaced Form #: AWD745AR-1 Previous Filing #:	50.600	ABJ745AR.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

MEDICAL EXAMINATION
AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
[1776 American Heritage Life Drive
Jacksonville, Florida 32224-6688]

Proposed Insured _____ Birthdate _____
First Name Middle Name Last Name Month Day Year

1. a. Name and address of your personal physician _____
(If none, so state)
b. Date and reason last consulted _____
c. What treatment was given or medication prescribed?

2. Have you ever been treated for or ever had any known indication of:	Yes	No
a. Disorder of eyes, ears, nose or throat?……	☐	☐
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?……	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?……	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels?……	☐	☐
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?……	☐	☐
f. Sugar, Albumin, blood or pus in urine, sexually transmitted disease; stone or other disorder of kidney, bladder, prostate, breasts, or reproductive organs?……	☐	☐
g. Diabetes, thyroid, or other endocrine disorders?……	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?……	☐	☐
i. Deformity, lameness or amputation?……	☐	☐
j. Disorder of skin, lymph glands, cyst, tumor or cancer?……	☐	☐
k. Allergies; anemia, or other disorder of the blood?……	☐	☐
l. Use of barbiturates, or amphetamines; marijuana, or any other hallucinatory drugs or heroin opiates, or other narcotics, except as prescribed by a doctor, or been treated or counseled for alcoholism?……	☐	☐
m. Any mental or physical disorder not listed above?……	☐	☐
3. Are you now under observation or taking treatment?……	☐	☐
4. Have you had any change in weight in the past year?……	☐	☐
5. Other than above, have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, surgery?……	☐	☐
b. Been a patient in a hospital, clinic, sanitarium, or other medical facility?……	☐	☐
c. Had an electrocardiogram, X-ray, other diagnostic test?……	☐	☐
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?……	☐	☐
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?.....	☐	☐
7. Have you ever requested or received a pension, benefits or payments because of an injury, sickness or disability?..	☐	☐
8. Family History: Tuberculosis, Diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?……	☐	☐
9. Are you a cigarette smoker?……	☐	☐
If yes, number of packs per day _____		
Have you been a cigarette smoker and quit?……	☐	☐
If yes, when did you last smoke?_____		

DETAILS of "Yes" answers. IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.

10.	Yes	No
a. Has any person to be insured, in the last 10 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus? ……..	☐	☐
b. In the last 2 years, have you had persistent cough, pneumonia, chest discomfort, muscle weakness, Kaposi's Sarcoma, unexplained weight loss of 10 or more pounds, swollen glands, patches in mouth, visual disturbances, or recurring diarrhea, fever or infection? …….	☐	☐

	Age, if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers & Sisters No. of Living _____			
No. Dead _____			

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other medical facility, **[**Pharmacy Benefit Managers,**]** insurance company, the Medical Information Bureau (MIB, Inc.) or other organization, institution or person, that has records or knowledge of me or my health **[**including my prescription medication history**]** to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

I represent that statements and answers given on this application are true, complete, and correctly recorded. **FRAUD NOTICE: Any person who knowingly and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.**

Date _____ _____
Signature of Proposed Insured

MEDICAL EXAMINER'S REPORT

11a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

12. Blood Pressure (Record ALL readings)

Systolic					
Diastolic (4th phase)					
Diastolic (5th phase)					

13. Pulse:

	At Rest	At Exercise	3 minutes Later
Rate			
Irregularities per min.			

14. Heart: Is there any:

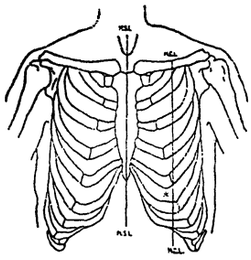
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(describe below – if more than one, describe separately)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Or. 1-2)	☐	☐
Mod. (Or. 3-4)	☐	☐
Loud (Or. 5-6)	☐	☐
After exercise:	☐	☐
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex by: X
Murmur area by: ☐
Point of greatest intensity by: v
Transmission by: λ



For comments and your impression?

15. Is there on examination any abnormality of the following:
(circle applicable items and give details.)

		Yes	No
a.	Eyes, ears, nose, mouth, pharynx?……	☐	☐
b.	Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?……	☐	☐
c.	Nervous system (include reflexes, gait, paralysis)?……..	☐	☐
d.	Respiratory system?……..	☐	☐
e.	Abdomen (include scars)?……	☐	☐
f.	Genitourinary system (including prostate)?……	☐	☐
g.	Endocrine system (include thyroid and breasts)?……	☐	☐
h.	Musculoskeletal system (include spine, joints, amputations, deformities)?……	☐	☐
16.a.	Are there any hernias? ……..	☐	☐
b.	any hemorrhoids?……	☐	☐
17.	Are you aware of additional medical history?…… (a confidential report may be sent to the Medical Director)	☐	☐
18.	Are you alone with proposed insured and unrelated to both the proposed insured and agent?……	☐	☐

Details of "yes" answers. (Identify item.)

URINALYSIS

a. Specific gravity? b. Reaction?

c. Albumin? Test used?

d. Sugar? Test used?
(Make note of slightest trace of albumin or sugar found on examination)

e. Has anyone ever claimed to have found casts, albumin or sugar in proposed insured's urine?

f. Are you forwarding a specimen of proposed insured's urine? (see note bottom of page)

g. **Always forward a urine specimen to Home Office Reference Lab. If no specimen will be forwarded, please explain circumstances.**

Name of Agent _____

I certify that I have carefully examined _____ of _____
(City and Street Address)

in private, at my office / his/her place of business / his/her home this _____ day of _____, 20 _____ at _____ a.m. / p.m.

Signature of Examiner _____ Address _____

_____ TAXPAYER IDENTIFICATION NUMBER _____
(Please print)

Review report carefully for completeness of all sections, then mail directly and without exception to the Medical Director at the Home Office of the Company
THE COMPANY APPRECIATES CONFIDENTIAL INFORMATION ALWAYS

SERFF Tracking #:	*ALST-128683900*	***State Tracking #:***		***Company Tracking #:***	*ABJ745AR*

State:	*Arkansas*	***Filing Company:***	*American Heritage Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Medical Examination*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification AR.pdf			

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

To the Forms Review Section, ARKANSAS Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

Form	Score
ABJ745AR	50.6

Date: September 13, 2012

Diane Ierna
Assistant Vice President, Compliance Department

American Heritage Life Insurance Company
1776 American Heritage Life Drive, Jacksonville, FL 32224 904-992-2711 DIerna@allstate.com